Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003916	A. BUILDING _____ B. WING _____	C 03/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00086741. Complaint IN00086741 - Substantiated. No deficiencies related to the allegations are cited. Survey date: March 23, 2011 Facility number: 003916 Provider number: 003916 AIM number: N/A Survey team: Connie Landman RN TC Census bed type: Residential: 56 Total: 56 Census payor type: Other: 56 Total: 56 Sample: 3 Autumn Glen Assisted Living Community was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00086741. Quality review completed 3/24/11 by Jennie Bartelt, RN.	R 000		